PATENT

IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

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Filing Date	:	October 17, 2001	
Applicants	:	Ryan Lance Levin et al.	
TC/A.U.	:	3626	
Examiner	:	Dilek B. Cobanoglu	
Docket No.	:	7802-A07-003	
Customer No.	:	33771	

APPEAL BRIEF

MS-APPEAL BRIEF-PATENTS
Commissioner for Patents
P.O. Box 1450
Alexandria, VA 22313-1450

Sir:

This Appeal Brief is being filed in response to a Final Office Action dated June 9, 2009. Reconsideration of the Application, withdrawal of the rejections, and allowance of the claims are respectfully requested.

I hereby certify that this correspondence is being deposited with the United States Postal Service with sufficient postage as first class mail in an envelope addressed to: Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450 or electronically transmitted to the U.S. Patent and Trademark Office on the date:
November 9, 2009, By: Paul Bianco /Paul Bianco /
Applicant, Assignee, or Representative

I. REAL PARTY IN INTEREST

The real party in interest is Discovery Life Limited of South Africa.

II. RELATED APPEALS AND INTERFERENCES

There are no related appeals or interferences.

III. STATUS OF CLAIMS

Claims 1-10, 12, and 14-19 are pending.

Claims 1-10, 12, and 14-19 are rejected.

Claims 11 and 13 are cancelled.

The Appellant is appealing the rejection of independent claims 1 and 18 (and all other remaining claims that depend from these claims). Claims 1 and 18 are on appeal.

IV. STATUS OF AMENDMENTS

The Examiner issued a Final Office Action dated June 9, 2009.

V. SUMMARY OF THE CLAIMED SUBJECT MATTER

This summary references page numbers and paragraph numbers of the Specification as originally filed.

The pending independent claims under appeal in this case are corresponding method claims. The following identifies the subject matter defined in each of the claims under appeal in the present application.

Independent method Claim 1 sets forth the following subject matter.

A) loading member application forms in a computer system managed by an insurance provider,: See at least FIG. 1 (under the "MH U/W Ops." column), FIG. 3 (under the "MH

Systems Dept." column), FIG. 7 (under the "Momentum Health Systems Dept" column), and FIG. 10 (under the "MH Systems Dept." column).

B) wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values;: See at least FIG. 1 (under the "MH U/W Ops." column); FIG. 3 (under the "MH Systems Dept." column); FIG. 7 (under the "Momentum Health Systems Dept" column); FIG. 10 (under the "MH Systems Dept." column); page 2, lines 9-11; and page 4, lines 13-23.

C) receiving, at the computer system managed by the insurance provider, one of a premium payment and a contribution payment from members of the medical insurance plan,: See at least page 2 lines, 17-18 and page 8, lines 1-5 and 25-27.

D) wherein the insurance provider undertakes liability in the medical insurance plan in response to receiving one of the premium payment and the contribution payment;: See at least page 2 lines, 17-18 and page 8, lines 1-5 and 25-27.

E) providing at least one of relevant health services and assistance in defraying expenses incurred in connection with rendering such relevant health services, by the computer system managed by the insurance provider to members who pay at least one of the premium payment and the contribution payment;: See at least page 2 lines, 17-25 and page 8, lines 1-5 and 25-27.

F) defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan;: See at least page 1, line 43; page 2, lines 37-41; an page 4,lines 25-27.

G) offering, by the computer system managed by the insurance provider, the at least one of a plurality of health-related facilities and a plurality of health-related services to members of the medical insurance plan;: See at least page 1, line 43; page 2, lines 37-41; an page 4,lines 25-27.

H) monitoring, by the computer system managed by the insurance provider, usage of the at least one of a plurality of health-related facilities and a plurality of health-related services by each member;: See at least FIG. 3; page 2, line 3; page 4, lines 25-33; and page 5 to page 7.

I) allocating, by the computer system managed by the insurance provider in response to the monitoring, a credit value to each member according to their use of the at least one of a plurality of health-related facilities and a plurality of health-related services; and: See the Abstract; FIG. 1; FIGs. 3-12; page 1, lines 39-41; page 2, line 1, lines 13-15, lines 27-37; page 3, lines 13-29; page 3, lines 41-47 to page 4, lines 1-23; page 5, lines 1-13 and 31-37; page 7m lines 39-47 to page 8, lines 1-11; page 8, lines 25-33; page 10, lines 1-7; page 11, lines 1-3; page 14, lines 19-21; and page 15, lines 7-15.

J) allocating, by the computer system managed by the insurance provider, rewards to members who accumulate credit values exceeding predetermined values. : See the Abstract; FIG. 1; FIGs. 3-12; page 1, lines 39-41; page 2, line 1, lines 13-15, lines 27-37; page 3, lines 13-29; page 3, lines 41-47 to page 4, lines 1-23; page 5, lines 1-13 and 31-37; page 7m lines 39-47 to page 8, lines 1-11; page 8, lines 25-33; page 10, lines 1-7; page 11, lines 1-3; page 14, lines 19-21; and page 15, lines 7-15.

Independent system Claim 18 sets forth the following subject matter.

A) loading member application forms in a computer system managed by an insurance provider;: See at least FIG. 1 (under the "MH U/W Ops." column), FIG. 3 (under the "MH Systems Dept." column), FIG. 7 (under the "Momentum Health Systems Dept" column), and FIG. 10 (under the "MH Systems Dept." column).

B) receiving, at the computer system managed by the insurance provider, one of a premium payment and a contribution payment from members of the medical insurance plan,: See at least page 2 lines, 17-18 and page 8, lines 1-5 and 25-27.

C) wherein the insurance provider undertakes liability in the medical insurance plan in response to receiving one of the premium payment and the contribution payment;: See at least page 2 lines, 17-18 and page 8, lines 1-5 and 25-27.

D) providing at least one of relevant health services and assistance in defraying expenses incurred in connection with rendering such relevant health services, by the computer system managed by the insurance provider to members who pay at least one of the premium payment and the contribution payment;: See at least page 2 lines, 17-25 and page 8, lines 1-5 and 25-27.

E) defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan;: See at least page 1, line 43; page 2, lines 37-41; an page 4,lines 25-27.

F) offering, by the computer system managed by the insurance provider, the at least one of a plurality of health-related facilities and a plurality of health-related services to members of the medical insurance plan;: See at least page 1, line 43; page 2, lines 37-41; an page 4,lines 25-27.

G) monitoring, by the computer system managed by the insurance provider, usage of the at least one of a plurality of health-related facilities and a plurality of health-related services by each member;: See at least FIG. 3; page 2, line 3; page 4, lines 25-33; and page 5 to page 7.

H) allocating, by the computer system managed by the insurance provider in response to the monitoring, a credit value to each member according to their use of the at least one of a plurality of health-related facilities and a plurality of health-related services; and: See the Abstract; FIG. 1; FIGs. 3-12; page 1, lines 39-41; page 2, line 1, lines 13-15, lines 27-37; page 3, lines 13-29; page 3, lines 41-47 to page 4, lines 1-23; page 5, lines 1-13 and 31-37; page 7m lines 39-47 to page 8, lines 1-11; page 8, lines 25-33; page 10, lines 1-7; page 11, lines 1-3; page 14, lines 19-21; and page 15, lines 7-15.

I) allocating, by the computer system managed by the insurance provider, rewards to members who accumulate credit values exceeding predetermined values.: See the Abstract; FIG. 1; FIGs. 3-12; page 1, lines 39-41; page 2, line 1, lines 13-15, lines 27-37; page 3, lines 13-29; page 3, lines 41-47 to page 4, lines 1-23; page 5, lines 1-13 and 31-37; page 7m lines 39-47 to page 8, lines 1-11; page 8, lines 25-33; page 10, lines 1-7; page 11, lines 1-3; page 14, lines 19-21; and page 15, lines 7-15.

VI. GROUNDS OF REJECTION TO BE REVIEWED ON APPEAL

A. Whether amendment filed February 17, 2009 introduced new material into the disclosure.

B. Whether claims 1-10 are unpatentable under 35 U.S.C. §103(a) over *Douglas et al.* (U.S. Patent No. 6,039,688) in view of *Luchs et al.* (U.S. Patent No. 4,831,526) further in view of *Applicant's admitted prior art*.

C. Whether claim 12 is unpatentable under 35 U.S.C. §103(a) over *Douglas et al.* (U.S. Patent No. 6,039,688) in view of *Luchs et al.* (U.S. Patent No. 4,831,526) further in view of *Applicant's admitted prior art* and in further view of *Ballantyne et al.* (U.S. Patent No. 5,867,821).

D. Whether 1.132 Declaration adds patentable weight to overcome the rejection under 35 U.S.C. §103(a) above.

VII. ARGUMENT

A. WHETHER AMENDMENT FILED FEBRUARY 17, 2009 INTRODUCED NEW MATERIAL INTO THE DISCLOSURE.

In the Examiner's Final Office Action of June 9, 2009, the Examiner objected to the Specification under 35 U.S.C. §132(a). In particular, the Examiner states:

> The added material which is not supported by the original disclosure is as follows: a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values (claims 1 and 19).

> In particular, the Applicant does not point to, nor was the Examiner able to find, any support for a "a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values" determination and display feature within the specification as originally filed.

The Appellant respectfully points out that support for the claim language "wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values;" can be found in the Specification as originally filed at, for example, FIG. 1 (under the "MH U/W Ops." column); FIG. 3 (under the "MH Systems Dept." column); FIG. 7 (under the "Momentum Health Systems Dept" column); FIG. 10 (under the "MH Systems Dept." column); and page 4, lines 13-23.

As can be seen, FIG. 1 shows under the "Employer" column that there is an "employer level decision" of "compulsory, voluntary*, or disallow Vitality membership for employees. This shows that the default setting is for all members to be opted-in in the Vitality membership. Further, on page 4, lines 13-23 of the Specification as originally filed shows that the employer can determine the level of membership made available to the employees and that this membership can be **compulsory** or voluntary. Each member is setup to "receive rewards based on accumulated credit values exceeding predetermined values". Page 2, lines 9-11 (and the remainder of the Specification in general) state that rewards are allocated "to members who accumulate credit values exceeding predetermined values". Accordingly, the Appellant submits that the claim language "wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values;" and that this objection to the Specification has been overcome and should be withdrawn.

It should be noted that even though some of the language was not *ipsis verbis* (not in the identical words) in specification the Examiner is respectively reminded that this language was sufficiently described in at least FIG. 1; page 2, lines 9-11; and page 4, lines 13-23 of the

Specification as originally filed, albeit not in the identical words.[1] Very recently the Federal Circuit in Allvoice Computing PLC v. Nuance Communications, Inc. (October 12, 2007) addressed the question of definiteness under 35 U.S.C. §112, 1st Par. and stated "*This court concludes that the reference to DDE in the specification is a structure corresponding to the "output means" clause of claim 60. With that understanding of the proper parameters of the claim, the record shows that an artisan of ordinary skill would understand the bounds of the claim when read in light of the specification. KSR Int'l Co. v. Teleflex Inc., 550 U.S. ----, 127 S.Ct. 1727, 1742 (2007) ("A person of ordinary skill is also a person of ordinary creativity, not an automaton."). Thus, the record shows that claim 60 satisfies the definiteness requirement.*"

Also, the exact terms need not be used *in haec verba* to satisfy the written description requirement of the first paragraph of 1.25 U.S.C. 112 *Eiselstein v. Frank*, 52 F.3d 1035, 1038, 34 USPQ2d 1467, 1470 (Fed. Cir. 1995); *In re Wertheim*, 541 F.2d 257, 265, 191 USPQ 90, 98 (CCPA 1976). See also 37 CFR 1.121(e), which merely requires *substantial* correspondence between the language of the claims and the language of the specification.

B. WHETHER CLAIMS 1-10 ARE UNPATENTABLE UNDER 35 U.S.C. §103(A) OVER *DOUGLAS ET AL.* (U.S. PATENT NO. 6,039,688) IN VIEW OF *LUCHS ET AL.* (U.S. PATENT NO. 4,831,526) FURTHER IN VIEW OF *APPLICANT'S ADMITTED PRIOR ART.*

The Examiner rejected claims 1-10 under 35 U.S.C. §103(a) as being unpatentable over *Douglas et al.* (U.S. Patent No. 6,039,688) in view of *Luchs et al.* (U.S. Patent No. 4,831,526) further in view of *Applicant's admitted prior art.*

[1] If, on the other hand, the specification contains a description of the claimed invention, albeit not in ipsis verbis (in the identical words), then the examiner or Board, in order to meet the burden of proof, must provide reasons why one of ordinary skill in the art would not consider the description sufficient. See In re Alton (Fed. Cir 1996) (Emphasis Added). See also Fujikawa v. Wattanasin (Fed. Cir. 1996), ipsis verbis, As the Board recognized, however, ipsis verbis disclosure is not necessary to satisfy the written description requirement of section 112. Instead, the disclosure need only reasonably convey to persons skilled in the art that the inventor had possession of the subject matter in question. In re Edwards, 568 F.2d 1349, 135152, 196 USPQ 465, 467 (CCPA 1978). See MPEP 2163 subsection II 3 (a), second to last paragraph.

The Appellant respectfully points out that although the Examiner originally stated claim 1-10 were rejected, the Appellant believes that the Examiner wanted to reject claims 1-10 and 14-19 under this rejection.

The Appellant respectfully suggests selection of independent Claim 1 as representative of the independent claims 1 and 18 on appeal. Independent Claim 1 is directed towards a method comprising:

> loading member application forms in a computer system managed by an insurance provider, wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values;
>
> receiving, at the computer system managed by the insurance provider, one of a premium payment and a contribution payment from members of the medical insurance plan, wherein the insurance provider undertakes liability in the medical insurance plan in response to receiving one of the premium payment and the contribution payment;
>
> providing at least one of
>
> relevant health services and
>
> assistance in defraying expenses incurred in connection with rendering such relevant health services, by the computer system managed by the insurance provider to members who pay at least one of the premium payment and the contribution payment
>
> defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan;
>
> offering, by the computer system managed by the insurance provider, the at least one of a plurality of health-related facilities and a plurality of health-related services to members of the medical insurance plan;
>
> monitoring, by the computer system managed by the insurance provider, usage of the at least one of a plurality of health-related facilities and a plurality of health-related services by each member;
>
> allocating, by the computer system managed by the insurance provider in response to the monitoring, a credit value to each member according to their use of the at least one of a plurality of health-related facilities and a plurality of health-related services; and
>
> allocating, by the computer system managed by the insurance provider, rewards to members who accumulate credit values exceeding predetermined values.

The claims were rejected under 35 U.S.C. §103(a). The Statute expressly requires that obviousness or non-obviousness be determined for the claimed subject matter "as a whole," and the key to proper determination of the differences between the prior art and the presently claimed invention is giving full recognition to the invention "as a whole." As discussed below, the Appellant asserts that these limitations, especially when considered in the context of the other limitations of Claim 1, are not described in the prior art references of record and that these limitations render the claimed subject matter non-obvious over the prior art.

Overview of Prior Art

The *Douglas* reference is directed to a therapeutic behavior modification program that is computer based. The *Douglas* reference teaches that a physician prescribes parameters and goals for a patient to achieve while participating in the modification program. A user (e.g., a patient) accesses the modification program via an electronic interface. The interface allows a user to participate with an interactive "village" and to enter data pertaining to the user's adherence to the program's parameters. A physician or case manager is able to track a user based on the information entered by the user via the interface. The *Douglas* reference further teaches that a physician or case manager can modify a user's program as the user progresses through the program. A health payor in the *Douglas* reference is only able to access the system to view compliance information and comparative cost information. **The *Douglas* reference does not teach that the health payor can do anything more than review compliance information and comparative cost information.**

The *Luchs* reference is directed to a computerized insurance system that processes and prepares applications for insurance and premium quotations. This system is also for preparing and writing insurance contracts. A central processor includes a data bank that can be written to or read from. The data within the data bank includes information regarding the risk to be insured, client information, insurance premium information, and predetermined text data for incorporation with insurance contracts. The central processor can also merge entered or stored data with predetermined text data to compile data embodying a final insurance document. This data is then communicated to a printer for printing of the insurance document.

Cited References Fail to Describe All Limitations

The *Douglas* reference teaches that a physician creates a program for an individual to follow (See the *Douglas* reference at FIG. 1, 2, 5, and 39 and col. 6, lines 7-25), whereas an insurance provider in the presently claimed invention has control over health related facilities and/or services and the rewards that are offered to individuals for participating in the health related facilities and/or services. Allowing an insurance provider to have control over these aspects as compared to a physical creating a program for an individual is advantageous because the insurance provider can tailor its offerings to suit its business goals and members. For example, the insurance provider knows what its members are submitting claims for and, by defining the facilities and services, the insurance provider is able to monitor the effect that their facility/service defining strategy is having on member claims. Therefore, the insurance provider is able to tailor the facility/services offered to its members to achieve maximum member claim reduction. Also allowing the insurance provider to tailor rewards offered to its members, the insurance provider is able to allocate specific rewards that will attract members likely to have lower number of claims.

With respect to claim 1, the Examiner states that the *Douglas* reference teaches:

> defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan (Douglas; col. 2, lines 9-22, col. 5, lines 28-34, col. 6, lines 7-13, 40-48);
>
> offering, by the computer system managed by the insurance provider, the at least one of a plurality of health-related facilities and a plurality of health- related services to members of the medical insurance plan (Douglas; Douglas; col. 2, lines 9-22, col. 5, lines 28-34, col. 6, lines 7-13, 40-48);

The Appellant respectfully disagrees because. Col. 2, lines 9-22, col. 5, lines 28-34, col. 6, lines 7-13, 40-48 of the *Douglas* reference are completely silent on these claim elements.

In the Response to Arguments section of the Final Office Action, the Examiner states:

> "Referring to FIG. 1, in a presently preferred embodiment of the invention, the patient 10, physician 12, case advisor 14, and health plan payor 16 (such as an HMO, insurance company or self-insured employer), all provide input to and/or receive output from the therapeutic behavior modification program's compliance monitoring and feedback system." (Douglas; col. 5, lines 28-34), therefore, payor inputs and receives output from the system.

As can be, the Examiner states that the *Douglas* reference teaches "defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan" merely because the *Douglas* reference states that an insurance company "provide[s] input to and/or receive[s] output from the therapeutic behavior modification program's compliance monitoring and feedback system".

However, all throughout the disclosure the *Douglas* reference only teaches that a physician "can then recommend a health care maintenance or recovery program which requires the patient to: take certain medications; participate in a support group; and control risk factors by altering his or her diet, following an exercise program, and managing stress levels." The *Douglas* reference also states that a physician can write a prescription for the program and then "send the information to a case advisor, who then sets the patient up on the system". The *Douglas* reference defines a case advisor as "doctor, nurse, and/or other trained medical professional experienced in case management protocols and practices". See the *Douglas* reference at col. 6, lines 7-27. Nowhere does the *Douglas* reference teach or suggest that the insurance provider defines "at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan". Merely stating that an insurance provider can provide input to and/or receive output from the system of *Douglas* does not render the presently claimed invention obvious especially when the *Douglas* reference explicitly teaches that it is the doctor or case advisor that places the patient into a program.

Also, the *Douglas* reference only states that an insurance provider can access the results of a user's participation in the health maintenance program of *Douglas*. See the *Douglas* reference at col. 19, lines 27-48. This further shows that only the doctor or case advisor of *Douglas* places a patient into the health maintenance program. The Appellant respectfully

suggests that the Examiner is improperly broadening the scope of the *Douglas* reference. For example, the *Douglas* reference only teaches that a health payor is only able to access the system to view compliance information and comparative cost information. See the *Douglas* reference at col. 19, lines 26-67 to col. 20, lines 1-18. These sections of the *Douglas* reference clearly show that the health payor does not define and offer health related facilities/services to a member, but merely reviews compliance and comparative cost information.

Even further, claim 1 recites "**defining**, by the computer system managed by the insurance provider, **at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan**". As can be seen, the insurance provider defines health-related facilities and/or health-related services that are to be associated with the medical insurance plan. A doctor or case advisor in *Douglas* determining goals, such as quitting smoking, is not the same as an insurance provider defining health-related facilities and/or health-related services that are to be associated with the medical insurance plan. A doctor in *Douglas* is merely setting goals and is not defining facilities and/or services to be associated with a medical insurance plan.

Accordingly, the presently claimed invention distinguishes over the *Douglas* reference for at least these reasons.

Additionally, the Examiner in the Response to Arguments section of the Final Office Action states:

> Also, Douglas teaches "In an exemplary scenario, a physician diagnoses an individual with an ailment. The physician may then recommend a health care maintenance or recovery program which requires the patient to: take certain medications; participate in a support group; and control risk factors by altering his or her diet, following an exercise program, and managing stress levels." (Douglas; col. 6, lines 7-13).
>
> Examiner considers that it makes more sense for a physician to recommend any health-relevant service such as exercising, since the physician knows about the patient's detailed health conditions, and can recommend the optimum program for the patient rather than an insurance company asking a patient to do a certain exercise. The system of Douglas offers the patient health-related services, wherein the health plan payor is a component of the system.

The Examiner seems to be inferring that even though the claims state "defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan" that it "makes more sense for a physician to recommend any health-relevant service such as exercising, since the physician knows about the patient's detailed health conditions, and can recommend the optimum program for the patient rather than an insurance company asking a patient to do a certain exercise". In other words, the Examiner seems to be acknowledging that the *Douglas* reference does not teach the presently claimed invention, but that this does not matter since it "makes more sense for a physician to recommend any health-relevant service such as exercising…". Accordingly, the presently claimed invention should be allowed for this reason.

With respect to the presently claimed "offering, by the computer system managed by the insurance provider, the at least one of a plurality of health-related facilities and a plurality of health-related services to members of the medical insurance plan", the Examiner cites the same sections of the *Douglas* reference discussed above. The remarks and arguments given above are also applicable to this claim element and for sake of compact prosecution will not be repeated. For example, nowhere does the *Douglas* reference teach or suggest that the insurance provider offer these facilities or facilities. The Examiner's comments in the Response to Arguments section of the Final Office Action of "The system of Douglas offers the patient health-related services, wherein the health plan payor is a component of the system" is improperly broadening the scope of the *Douglas* reference. Just because the system of *Douglas* provides the on-line community for the user to participate in does not teach or suggest that the health plan payor offers these services. It is irrelevant that the health plan payor is part of the system because the presently claimed invention recites that the insurance provider itself provides the facilities and/or services. Accordingly, the presently claimed invention distinguishes over the *Douglas* reference for at least these reasons as well.

The Examiner further states that the *Douglas* reference teaches:

> allocating, by the computer system managed by the insurance provider in

> response to the monitoring, a credit value to each member according to their use of the at least one of a plurality of health-related facilities and a plurality of health-related services (Douglas; col. 5, lines 28-34, col. 14, lines 38-42); and
>
> allocating, by the computer system managed by the insurance provider, rewards to members who accumulate credit values exceeding predetermined values (Douglas; col. 14, lines 42-47)

Col. 5, lines 28-34 of the *Douglas* reference merely state that a health payor and other entities such as a physician can provide input into the system. As discussed above, col. 19, lines 26-67 to col. 20, lines 1-18 explicitly teach how the health payor interacts with the system, which does not include allocated credit vales to members based on health related facility/service usage or allocating a reward(s) to the member based on the credit values. Col. 14, lines 38-42 of the *Douglas* reference merely state that a user can earn points, but these points are awarded by the behavior modification program and not by the insurance provider. Col. 14, lines 42-47 of the *Douglas* reference merely state that the user can be given rewards, but these rewards are given by the behavior modification program and not by the insurance provider. Also, nowhere does the *Douglas* reference teach that the rewards are allocated to members who accumulate credit values exceeding predetermined values. The *Douglas* reference does not require the rewards to be allocated only when the accumulated credit value exceed a predetermined value(s). In other words, the *Douglas* reference merely gives rewards for finishing a program, etc. For example, the *Douglas* reference at col. 19, lines 38-52 states:

> Users may earn points by good participation in the program and by reaching certain milestones. For instance, points may be earned for good attendance at meetings, good participation during the meetings, chairing a meeting, or losing a certain amount of weight, if this was a goal to be accomplished.
>
> Rewards range from the symbolic kind, such as getting "gold stars" that commend a user for his or her progress, to reward points and frequent flier miles which may be exchanged for goods in the village store 78 or plane tickets in the village travel agency 82, respectively.

As can be seen, nowhere does the *Douglas* reference teach or suggest "that the rewards are allocated to members who accumulate credit values exceeding predetermined values". The above teaching of the *Douglas* reference does not teach or suggest "credit values exceeding predetermined values".

Accordingly, the presently claimed invention distinguishes over the *Douglas* reference for at least these reasons.

The Examiner correctly states that the *Douglas* reference does not teach:

> loading member application forms in a computer system managed by an insurance provider, wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding a predetermined values.

The Examiner goes on to combine the *Douglas* reference with the *Luchs* reference stating that the *Luchs* reference teaches "a series of data comprising a form"(Luchs; abstract, col. 2, lines 26-30, col. 3, lines 17-38)." However, at best, the *Luchs* reference merely teaches insurance information on a form. See the *Luchs* reference in general. However, nowhere does the *Luchs* reference teach or suggest "wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding a predetermined values". Nowhere does the *Douglas* reference teach this claim element either. Accordingly, the presently claimed invention distinguishes over the *Douglas* and the *Luchs* references alone and/or in combination with each other for at least these reasons.

The *Applicant's Admitted Prior Art* does not overcome the deficiencies of the *Douglas* and the *Luchs* references discussed above.

Independent claims 18 recites similar to independent claim 1 discussed above (with the exception of the "wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding a predetermined values" element). Therefore, the remarks and arguments made above with respect to independent claim 1 are also applicable in support of independent claim 18 and for sake of compact prosecution will not be repeated.

Accordingly, the presently claimed invention distinguishes over *Douglas*, *Luchs*, and *the Applicant's Admitted Prior Art* alone and/or in combination with each other for at least these reasons.

Therefore, in view of the remarks and arguments given above independent claims 1 and 18 (and their dependent claims) distinguish over *Douglas*, *Luchs*, and *the Applicant's Admitted Prior Art* either alone and/or in combination with each other. In view of the foregoing remarks and arguments the rejection of claims 1-10, 12, and 14-19 should be reversed.

C. WHETHER CLAIM 12 IS UNPATENTABLE UNDER 35 U.S.C. §103(A) OVER *DOUGLAS ET AL.* (U.S. PATENT NO. 6,039,688) IN VIEW OF *LUCHS ET AL.* (U.S. PATENT NO. 4,831,526) FURTHER IN VIEW OF *APPLICANT'S ADMITTED PRIOR ART* AND IN FURTHER VIEW OF *BALLANTYNE ET AL.* (U.S. PATENT NO. 5,867,821).

The Examiner rejected claim 12 under 35 U.S.C. §103(a) as being unpatentable over *Douglas et al.* (U.S. Patent No. 6,039,688) in view of *Applicant's admitted prior art* and in further view of *Ballantyne et al.* (U.S. Patent No. 5,867,821).

The Examiner correctly states o page 18 of the present Office Action that *Douglas* does not "expressly teach the vaccination information". However, the Examiner goes on to combine *Douglas* with *Ballantyne* to overcome the deficiencies of *Douglas*. The remarks and arguments given above with respect to claims 1 and 18 are also applicable here and for sake of compact prosecution will not be repeated. Claim 12 depends from claim 1 and *Douglas* individually and/or in combination with *Applicant's Admitted Prior Art* and *Ballantyne* does not teach or suggest:

The Appellant respectfully suggests selection of independent Claim 1 as representative of the independent claims 1 and 18 on appeal. Independent Claim 1 is directed towards a method comprising:

> loading member application forms in a computer system managed by an insurance provider, wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values;
>
> receiving, at the computer system managed by the insurance provider, one of a premium payment and a contribution payment from members of the medical insurance plan, wherein the insurance provider undertakes liability in the medical insurance plan in response to receiving one of the premium payment and the contribution payment;
>
> providing at least one of

relevant health services and

assistance in defraying expenses incurred in connection with rendering such relevant health services, by the computer system managed by the insurance provider to members who pay at least one of the premium payment and the contribution payment

defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan;

offering, by the computer system managed by the insurance provider, the at least one of a plurality of health-related facilities and a plurality of health-related services to members of the medical insurance plan;

monitoring, by the computer system managed by the insurance provider, usage of the at least one of a plurality of health-related facilities and a plurality of health-related services by each member;

allocating, by the computer system managed by the insurance provider in response to the monitoring, a credit value to each member according to their use of the at least one of a plurality of health-related facilities and a plurality of health-related services; and

allocating, by the computer system managed by the insurance provider, rewards to members who accumulate credit values exceeding predetermined values.

Accordingly, the presently claimed invention distinguishes over *Douglas*, the *Admitted Prior Art*, and *Ballantyne* either alone and/or in combination with each other. Therefore, the Appellant respectfully suggests that the rejection of claim 12 under U.S.C. § 103(a) has been overcome and should be withdrawn.

D. WHETHER THE 1.132 AFFIDAVIT ADDS PATENTABLE WEIGHT TO OVERCOME THE REJECTION OF CLAIMS 1-10 UNDER 35 U.S.C. §103(A) OVER *DOUGLAS ET AL.* (U.S. PATENT NO. 6,039,688) IN VIEW OF *LUCHS ET AL.* (U.S. PATENT NO. 4,831,526) FURTHER IN VIEW OF *APPLICANT'S ADMITTED PRIOR ART* AND/OR IN VIEW OF *APPLICANT'S ADMITTED PRIOR ART* IN FURTHER VIEW OF *BALLANTYNE ET AL.* (U.S. PATENT NO. 5,867,821).

Reconsideration of the rejection of claims 1-10, and 14-17 under 35 U.S.C. §103(a) as being unpatentable over *Douglas* et al. (U.S. Patent No. 6,039,688) in view of *Applicant's admitted*

prior art and claim 12 under U.S.C. § 103(a) as being unpatentable over *Douglas* et al. (U.S. Patent No. 6,039,688) in view of *Applicant's admitted prior art* and in further view of *Ballantyne* et al. (U.S. Patent No. 5,867,821), is respectfully requested for the following reasons.

On page 5 of the October 17, 2008 Office Action, the Examiner concluded that "it would have been obvious to one of ordinary skill in the art at the time of the invention to include the aforementioned limitation as disclosed by *Applicant's admitted prior art*, which is the definition of the medical plan, with motivation of providing clarification of the benefits of insurance."

It appears, from the statements made by the Examiner as shown above, that the Examiner is asserting a factual basis for the obviousness rejection, which is the Examiner's personal knowledge of this technical field as one of ordinary skill in the art.

This factual finding by the Examiner as one of ordinary skill in the art, and not from any of the cited references, necessitates that the Appellant present into the record evidence of non-obviousness by way of a 132 Declaration and associated UBS Investment Research. The attached 132 Declaration and associated UBS Investment Research are submitted in response to the Examiner's factual finding in the October 17, 2009 Office Action, on page 5. The Appellant respectfully requests that the Examiner enter the 132 Declaration and associated UBS Investment Research, into the record for this application.

Specifically, Michael Christelis is an analyst for UBS South Africa, which is independent from the assignee of the present invention (Discovery Life Limited). Michael Christelis is the author of the UBS Investment Research. A copy of the UBS Investment Research is attached. On page 12 of the UBS Investment Research, Michael Christelis describes "*Key Advantage: Vitality. Can it be copied?"* In this section, Michael Christelis enumerates three reasons for the commercial success of the claim invention (The Vitality System) with bullet points entitled "*Innovations, 'Opt-out' rather than 'opt in' and Integration*." This corresponds to the language recited in independent claim 1 and dependent claim 19 of <u>wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values.</u> This is the "opt in" innovation cited

in the UBS Investment Research report. Also independent claim 1 and 18 recites a computer system managed by an insurance provider. The insurance provider provides this integration. These are the reasons for the market success of the claimed invention (The Vitality System) as reported by UBS South Africa. This market success shows the nexus to the claim language of "wherein the insurance provider undertakes liability in the medical insurance plan in response to receiving one of the premium payment and the contribution payment." The Examiner cites investment boilerplate language to point out that "UBS does and seeks to do business with companies covered by research reports." However, there is no evidence that UBS does business with Discovery Life Limited, nor has UBS done business with Discovery Life Limited. Further the Examiner points to other language to support the argument that the report provides other reasons for success of Vitality. However, as stated in the report, the "key advantage" has been unambiguously highlighted. Therefore, it was not obvious for the person of ordinary skill in the art to arrive at the language of independent claims 1 and 18.

CONCLUSION

For the reasons stated above, the Appellant respectfully contends that each claim is patentable. Therefore, reversal of all rejections is courteously solicited.

Respectfully submitted,

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VIII. CLAIMS APPENDIX

1. A method of managing the use of a medical insurance plan by members thereof, the method comprising:

loading member application forms in a computer system managed by an insurance provider, wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values;

receiving, at the computer system managed by the insurance provider, one of a premium payment and a contribution payment from members of the medical insurance plan, wherein the insurance provider undertakes liability in the medical insurance plan in response to receiving one of the premium payment and the contribution payment;

providing at least one of

relevant health services and

assistance in defraying expenses incurred in connection with

rendering such relevant health services,

by the computer system managed by the insurance provider to members who pay at least one of the premium payment and the contribution payment;

defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan;

offering, by the computer system managed by the insurance provider, the at least one of a plurality of health-related facilities and a plurality of health-related services to members of the medical insurance plan;

monitoring, by the computer system managed by the insurance provider, usage of the at least one of a plurality of health-related facilities and a plurality of health-related services by each member;

allocating, by the computer system managed by the insurance provider in response to the monitoring, a credit value to each member according to their use

of the at least one of a plurality of health-related facilities and a plurality of health-related services; and

allocating, by the computer system managed by the insurance provider, rewards to members who accumulate credit values exceeding predetermined values.

2. Currently Amended) The method according to claim 1, wherein the at least one of a plurality of health-related facilities and a plurality of health-related services includes at least one of the group consisting of:

membership of health clubs,
membership of gymnasiums,
membership of fitness programs,
weight loss programs, and
programs to quit smoking.

3. The method according to claim 2, wherein the at least one of a plurality of health-related facilities and a plurality of health-related services further includes predetermined preventive medical procedures.

4. The method according to claim 2, wherein the at least one of a plurality of health-related facilities and a plurality of health-related services further includes a medical advice service.

5. The method according to claim 2, wherein the at least one of a plurality of health-related facilities and a plurality of health-related services further includes predetermined procedures.

6. The method according to claim 5, wherein the predetermined procedures include at least one of the group consisting of

advance pre-authorization of hospitalization,
advance pre-authorization of treatment,
registration for electronic funds transfer, and
compliance with preferred procedures.

7. The method according to claim 1, wherein a reward allocated to a member is at least one of linked to a number of annual claims associated with the member and whether or not the member has been hospitalized in a predetermined period of time.

8. The method according to claim 7, wherein the reward allocated to the member includes at least one of the group consisting of:

prizes allocated on a basis of a draw,

a magnitude of a member's credit value being related to a chance of winning the draw,

access to at least one of health-related facilities and health-related services for family members,

decreased premium payments according to a predetermined plan, and

increased benefit payments according to a predetermined plan.

9. The method according to claim 1, wherein a reward allocated to a member is not actually given to the member before at least one of a predetermined period has passed or the member has attained a predetermined age.

10. The method according to claim 9, wherein the reward allocated is forfeited by the member if they are not still a member of the medical insurance plan after the predetermined period has passed or after the member has attained such predetermined age.

11. (Canceled)

12. The method according to claim 3, wherein the preventive medical procedures include vaccinations.

13. (Canceled)

14. The method according to claim 1, further comprises:

the insurance provider offering the at least one of a plurality of health-related facilities and a plurality of health-related services in conjunction with third party service providers that provide at least one of health related facilities and health-related services in the at least one of a plurality of health-related facilities and a plurality of health-related services offered by the insurance provider; and

monitoring usage of the at least one of health-related facilities and health-related services provided by the third party service providers by members by receiving information from the third party service providers detailing the usage of the at least one of health- related facilities and health-related services by the members.

15. The method according to claim 14, wherein the members only pay a once off activation fee to gain access to the at least one of a plurality of health-related facilities and a plurality of health-related services.

16. The method of claim 1, further comprising:

providing, by the insurance provider, one of a full payment and a partial payment to one of a health-related facility and a health-related service in the at least one of a plurality of health-related facilities and a plurality of health-related services that has been used by a member of the medical insurance plan, wherein the one of a full payment and a partial payment is on behalf of the member.

17. The method of claim 1, further comprising:

providing, by the insurance provider, discounted usage fees to the members for the at least one of a plurality of health-related facilities and a plurality of health-related services.

18 A method of managing the use of a medical insurance plan by members thereof, the method comprising:

loading member application forms in a computer system managed by an insurance provider;

receiving, at the computer system managed by the insurance provider, one of a premium payment and a contribution payment from members of the medical insurance plan, wherein the insurance provider undertakes liability in the medical insurance plan in response to receiving one of the premium payment and the contribution payment;

providing at least one of

relevant health services and

assistance in defraying expenses incurred in connection with

rendering such relevant health services,

by the computer system managed by the insurance provider to members who pay at least one of the premium payment and the contribution payment;

defining, by the computer system managed by the insurance provider, at least one of a plurality of health-related facilities and a plurality of health-related services to be associated with the medical insurance plan;

offering, by the computer system managed by the insurance provider, the at least one of a plurality of health-related facilities and a plurality of health-related services to members of the medical insurance plan;

monitoring, by the computer system managed by the insurance provider, usage of the at least one of a plurality of health-related facilities and a plurality of health-related services by each member;

allocating, by the computer system managed by the insurance provider in response to the monitoring, a credit value to each member according to their use of the at least one of a plurality of health-related facilities and a plurality of health-related services; and

allocating, by the computer system managed by the insurance provider, rewards to members who accumulate credit values exceeding predetermined values.

19. The method according to claim 18, wherein a default setting associated with the medical insurance plan is for all members to be opted-in to receive rewards based on accumulated credit values exceeding predetermined values.

IX. EVIDENCE APPENDIX

NONE

X. RELATED PROCEEDINGS APPENDIX

NONE